OMB Control No. 1810-0021 (Exp. 06/30/2026)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child ______________________________ Date of Birth __________ Grade level __________

Name of School ______________________________ School District ______________________________

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: ______________________________

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name ______________________________ Address ______________________________

City ______________________________ State ______ Zip Code __________

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). ______________________________

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian ______________________________ Signature ______________________________

Address ______________________________ City ______________________________ State ______ Zip Code __________

Phone Number ______________________________ Email ______________________________ Date ______________

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

Strong Family Health Center
1203 Oak St.
Alturas CA. 96101

Date:__________________

Emergency Contact and Allergies

Please fill out one form per child and list any **food, insect, asthma, or medication allergies that each child has. If the child has no allergies please write "None"**. For questions or concerns please contact the SFHC Youth Department at (530) 233-4591.

Child's Name:____ Child's Birth Date: __________________

Allergies (medicine/food/bee's, etc.): ____

Reaction: ____

Current Medications, including inhalers, Epi Pens, etc.

____

PARENT/GUARDIAN #1

Name: ____ Home Phone: __________________

Cell Phone: __________________

Work Phone: __________________

PARENT/GUARDIAN #2:

Name: ____ Cell Phone: __________________

Work Phone: __________________

(At least one other emergency contact is required)

EMERGENCY CONTACT #1:

Name: ________________________ Relationship to child: ___________________ Phone: _______________

Address: ____

EMERGENCY CONTACT #2:

Name: ________________________ Relationship to child: ___________________ Phone: _______________

Address: ____

August 2024

Strong Family Health Center
Student Contract

Student Initials_____ I agree to attend and participate in youth activities because I want to be here, not because I have to be here and my attitude will reflect that.

Student Initials_____ I agree to treat everyone with respect, I will listen politely when others are talking, I will not call names or treat others badly. I will not be a bully.

Student Initials_____ I agree to keep my hands, feet, and other objects to myself.

Student Initials_____ I understand that on tutoring days I am here to learn and complete my current homework, missing work or work on skill building activities. I will bring my work with me. Tutoring days are not free time play days.

Student Initials_____ I agree to bring my homework/missing work/AR book to tutoring. I understand that it is my responsibility to come prepared and ready to work. It is not the responsibility of my tutor/teacher or parents. I will do my best.

Student Initials_____ **All cell phones must be placed into the basket at tutors request.** Phones will be given back after a tutor has confirmed work is completed. All use of cell phones during group, must be appropriate. i.e. music, games, youtube, social media, no cyberbullying, etc. Chromebooks are available for homework use.

Student Initials_____ I agree to follow directions and help clean up when group is over.

Student Initials_____ I agree that if I have a problem, someone hurts me or I feel unsafe, to let the youth group leaders know so they can take care of the problem.

Student Initials_____ I agree to respect and honor all SFHC and other peers properties while I am here. I also agree to be respectful of all other properties that I may visit while with the SFHC youth group.

Student Initials_____ I agree to use my indoor voice while in the building and will not run around and disrupt others.

August 2024

Student Initials______ I will respect the Youth Leaders while participating in all activities at Strong Families.

Student Initials____ I will not use inappropriate language or hurtful speech while participating at Strong Families.

Student Initials____ I understand that I must stay within the youth centers safe spaces and that the Youth Staff are the only ones who can open doors that lead outside of these safe spaces. This includes if my parents are at the door/gate.

The following are the consequences of not following the above rules:

1st time- Verbal Warning
2nd time- Phone call home to my parents
3rd time- Student, parents and staff review contract and consequences
4th time- Student will not be able to attend one day of group
5th time- Suspension from the program until the following school year
* In extreme situations SFHC may move to any step in the consequence list.

I agree to the above rules and consequences.

Child's Signature________________________________ Date_______________

Parent's Signature_______________________________ Date_______________

Sincerely,
Strong Family Health Center
Youth Department

Strong Family Health Center

"Comprehensive Tribal Healthcare"

1203 Oak St. Alturas, CA. 96101-3225

Phone (530)233-4591 Fax (530)233-3055

RELEASE OF INFORMATION:

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

The purpose for this information is to provide up to date Medical, Dental, Mental Health, Vision and/or Education support and services.

Client Name: ______________________ D.O.B ___/___/___ S.S.N. ______________

______________________________________ (______)______________

Physical Address City/State/Zip Code Phone Number

______________________________________ (______)______________

Mailing address City/State/Zip Code Cellular Number

Please provide the name and contacts numbers of your health care providers in the space given below.

Medical Doctor: ______________________________

Dentist: ______________________________

Eye Doctor: ______________________________

Hospital: ______________________________

Specialty Care: ______________________________

Mental Health Provider: ______________________________

Federally Recognized Tribes (Specify): ______________ Band/Clan: ______________

School: MJUSD, MCOE, MVA______________________________

Dept. of Social Services: Modoc County______________________________

Other (Specify): ______________________________

I authorize the release of protected healthcare information (PHI) by provider that I see and their out-sourced billing associates. In addition, Strong Family Health Center (SFHC) is my payer of last resortand should be billed as such. I authorize my providers to address SFHC with any billing/paymentissues. Provider may disclose my PHI necessary for medical appointment, treatments, consultations, billing claims and payments. This authorization shall be inforce and effective until 2 years fromsignature date at which time this authorization expires. I understand that I have the right to revoke thisauthorization in writing, at any time, but in doing so the revocation may limit my PRC services. Iunderstand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

______________________________ ______________________

Signature of Client Date

______________________________ ______________________

Parent/Guardian of Minor Client Date

______________________________ ______________________

Signature of Witness (If Signed with an X) Date

This information is to be release for the purpose stated above and my not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning and individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C 552a (1) (3). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31 (d) 12/12

ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH **Strong Family Health Center** including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being release, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.

I certify that there are no health-related reasons or problems which preclude my participation in this activity.

I acknowledge that this Accident Waiver and Release of Liability Form will be used by the event holders, sponsors, and organizers of the activity in which I or my child may participate, and that it will govern my actions and responsibilities at said activity.

In consideration of my child's permission slip and permitting them/me to participate in this activity, I hereby take action for myself and or child, executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me or my child including their transportation to and home from this activity, THE FOLLOWING ENTITIES OR PERSONS: Strong Family Health Center (SFHC) and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

I acknowledge that SFHC and their directors, officers, volunteers, representatives, and agents are not responsible for the errors, ommisions, acts, or failures to act of any party or entity conducting a specific activity on their behalf.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.

I understand while participating in this activity, I or my child may be photographed by the activity holders, producers, sponsors, organizers and assigns. I also understand that SFHC is not responsible for any lost or stolen items.

The accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

____

Participant's Signature   Date   Participants Name   Age

____

Parent/Guardian Signature   Date

ELECTRONIC PERMISSIONS

Schools use computerized systems for tracking student grades. These online tracking systems/programs make it possible to monitor your child's progress on a daily basis. It would be helpful for the SFHC youth department staff to have the same access to your child's information. Having timely grade reports will help staff to better assist your child at tutoring. It allows us to check for any missing assignments, upcoming tests and other pertinent information in order to see where supports can be implemented.

In order to do this, we need your signature/permission on the bottom of this form. By signing this permission form, you are allowing Strong Family Health Center access to all forms of electronic systems used by your students' school for education purposes. If you have any questions or concerns please call us at (530) 233-4591.

Sincerely,

Strong Family Health Center
Youth Department

As the parent or legal guardian of:

Child's Name: ____

I hereby give permission for Strong Family Health Center to have full access to my Child/Children's academic information on all educational platforms used by Modoc Joint Unified School District or
(Name of school if different):__________________________ .

Signed: ______________________________ Date: ____________________

STRONG FAMILY HEATLH CENTER PHOTO RELEASE

I hereby grant Strong Family Health Center permission to take use my photos and acknowledge my participation in a photograph, video or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Strong Family Health Center.

I hereby irrevocably authorize Strong Family Health Center to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Strong Family Health Center from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE IS FOR MYSELF AND MY MINOR CHILD LISTED BELOW.

Minors name: ______________________________________

Parent/Guardians Name: ______________________________________

Parent Signature: ________________________ Date: ____/____/____

Parent Acknowledgement and Agreement

Strong Family Health Center's vision for the youth program is that "all students will be empowered to succeed academically and will possess the skills they need to realize their potential and achieve their hopes and dreams."

Strong Family Health Center (SFHC) holds the contract with Modoc Joint Unified School District to administer the Title VI Indian Student Education Program. Per our contract; SFHC will provide the following services:

1. An adult to provide tutoring services for qualified Native American students at MJUSD school sites for the current school year.

2. Emphasize individual student needs for grades K-12 in the basic academic areas (Math and Reading/Language Arts). Teach students in grades 6-12 organizational and time management skills, including how to study for exams and assist in the preparation and completion of long-term assignments.

The tutors are unable to help students reach these goals if students come unprepared to learn. The Title VI program is a voluntary program, attendance is not mandatory. So please consider whether this program is a good fit for your child and family, we hope that it is. That being said, in previous school years we have had on-going issues with students coming unprepared, being disruptive to other students. Here are some important reminders regarding the rules of the SFHC tutoring program.

1. It is <u>required</u> that students bring their homework/missing work and AR book to the after school tutoring program. If a student is unprepared to work, it will be expected that the student will AR read for the duration of tutoring.
2. Parents, please do not drop off your child without their homework/missing work or AR book. A parent/guardian will need to check the student in with youth staff at drop off.
3. Students will come to SFHC ready to participate and not disrupt others or our tutor's limited time. If a child is disruptive, parents will be called and must come and pick them up within 30 minutes. If you do not pick up your child when it is requested, your child will not be eligible to participate in the next scheduled activity.
4. **It is vital that we have a current working phone number to contact you as well as a working phone number and address for an alternate emergency contact person.**

Enclosed is a student contract that all students and parents need to fill out and return before the student will be allowed to begin participating. As the program continues to grow, the youth staff do not have the time to continually be redirecting students. Please discuss as a family if you feel the program will be a good fit for your children and remind them of the SFHC youth program rules. Only families that have filled out and returned this contract will be permitted to continue participating in the youth/tutoring programs at SFHC for the current year.

If you have any questions please contact our office at: 233-4591.

Sincerely,

Strong Family Health Center
Youth Department

*** Parent Initial** ______ I acknowledge that I have received a copy of the *Youth Program Policy dated December 30th, 2020*

***Parent Initial** ______ I give the Strong Family Health Center staff permission to leave my child (6th grade or above) at home **alone.**

***Parent Initial** ______ I understand that my child/children will not be picked up from school or allowed to participate in the youth program until the current SFHC school years packet has been signed and returned.

X________________________________ Date ____________________
Signature

X________________________________
Print Name